Urgent Care Hawaii
where amazing healthcare happens

PATIENT REGISTRATION FORM

PATIENT INFORMATION

SSN:_____ Home Phone:_____

First Name:_____ Cell Phone:_____

Last Name:_____ Email Address:_____

Middle Name:_____ Date of Birth:____/____/____

Address:_____

How did you hear about us? ❑ Established ❑ Friend/Family ❑ Insurance ❑ Employer ❑ Other (*Please specify*) ❑ Event ❑ Doctor Referral ❑ Internet ❑ Drive By _____

Sex: ❑ M OR ❑ F Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ YES ❑ NO

Preferred Pharmacy Location:_____

**Please indicate specific location and city of preferred pharmacy.*

Primary Care Physician:_____ Phone Number:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone Number:_____

PERSONAL INSURANCE COVERAGE

Primary Insurance:_____ Secondary Insurance:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Member ID Number:_____ Member ID Number:_____

Group Number:_____ Group Number:_____

Policy Holders SSN:_____ DOB:___/___/___ Policy Holders SSN:_____ DOB:___/___/___

Relationship to Patient:_____ Relationship to Patient:_____

GUARANTOR'S INFORMATION *(Please complete if you are filling out registration form for patient under 18yrs)*

First Name:_____ Last Name:_____

Date of Birth:_____ SSN:_____

Address:_____

Street Address *City/State/Zip Code*

I certify that the information provided is correct to the best of my knowledge. I will not hold US Med Urgent Care, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

You may be contacted by WOWZA Management Billing, acting on behalf of US Med Urgent Care regarding any financial responsibilities.

Patient Signature **Date**

_____

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NOTICE OF PRIVACY PRACTICES

CONSENT FOR TREATMENT

Urgent Care Hawaii, LLC and their employees evaluate and treat the above patient for medical complaint and illnesses. This includes taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, obtaining of X-rays for diagnosis, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All of my information will remain confidential. I acknowledge that I have been offered a copy of Urgent Care Hawaii, LLC Notice of Privacy Practices.

Initial:_____

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information and payment of medical benefits to Urgent Care Hawaii, LLC for services necessary to process this claim and any future claims. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Initial:_____

FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment of professional services.
PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE: Co-payment will be collected before you are seen. Payment can be made by cash, check or credit card. If you have insurance that we do not participate with, our office will be happy to file the claim upon request; however payment in full is expected at the time of service. If you have questions about your insurance coverage, we will be happy to assist you. Specific coverage issues should be directed to your insurance company. It is however, understood and agreed that the Responsible Party is responsible for all monies due for services rendered in the event insurance does not pay for these services rendered in the event insurance does not pay for these services. ALL CHARGES ARE AN ESTIMATE AND FINALIZED WHEN YOUR INSURANCE COMPANY PROCESSES YOUR CLAIMS.

Initial:_____

In addition, a Pre-Authorization up to the amount of $100 can be held for those charges not paid by your insurance. The Pre-Authorization amount is not charged against the current credit/debit card transaction being processed, unless you have chosen to continue to use this card. The amount is saved for later reference and will be released within 90 days.

Initial:_____

A 20% DISCOUNT is already applied to the total bill for patients paying self-pay prices at the time of service. This discount does not apply to patients with insurance. If laboratory tests must be sent to an outside source for further evaluation, the responsible party understands they will be responsible for charges from that facility.

Initial:_____

NOTE: It is company policy to run your check by EFT or your credit card. For private pays (no insurance) all charges for the visit is due before you are seen visit. If you have insurance, you may have a balance at the end of your visit, which must be paid before you exit the clinic. Upon departure, please note that the aging of your statement will begin until your balance has been paid in full by your insurance or by yourself and/or guardian.

By signing below, I agree that I have read and understand the terms of this agreement.

Print Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ **Date:**_____